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## Teviot Place now:— The Edinburgh Medical School in 1978

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### Abstract

In the history of every Medical School there are periods of calm and times of intense activity. Some of the medical teachers in Edinburgh have already experienced three very active phases. First there was 1939 when there occurred the trauma and disruption of World War II. Seven years later came the immediate post-war period, when new members of staff were being recruited, former teachers were returning, and the intake included a large number of 'mature' students. The third peak of activity, which overlapped with the second, was in 1948 when the National Health Service was introduced and the teachers in general found themselves becoming employees either of the University or the N.H.S., not always being allotted to the employer of their own choice. Some would say that a fourth time of unusual activity was in 1963 when a new curriculum was introduced.

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# Comment and Reflections

Teviot Place now:—

## THE EDINBURGH MEDICAL SCHOOL IN 1978

by

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In the history of every Medical School there are periods of calm and times of intense activity. Some of the medical teachers in Edinburgh have already experienced three very active phases. First there was 1939 when there occurred the trauma and disruption of World War II. Seven years later came the immediate post-war period, when new members of staff were being recruited, former teachers were returning, and the intake included a large number of 'mature' students. The third peak of activity, which overlapped with the second, was in 1948 when the National Health Service was introduced and the teachers in general found themselves becoming employees either of the University or the N.H.S., not always being allotted to the employer of their own choice. Some would say that a fourth time of unusual activity was in 1963 when a new curriculum was introduced.

At present we are faced with many challenges, which are not necessarily difficulties, except that our administrative staff have to reconcile the many changes that are occurring simultaneously. To this must be added the problems that the administrators have in dealing with each other, because the dust has not yet settled after the reorganization of the National Health Service. The bewildered clinical teacher finds that the University administrative pattern is relatively simple, since he does not require even to know of the existence of many of the central University committees, but he is at a

loss to understand the functions of many of the National Health Service committees even although they may impinge directly upon his work. More importantly he may find it difficult to understand the intended absence of others that formerly existed, but were officially declared unnecessary, and which have now crept back because he and his colleagues find them useful or even essential.

Few things are as dull to discerning medical students as committees. Pre-clinical medicine may excite interest or fury, and clinical medicine is so protean in its interests that it holds the attention. It is to be expected that most students will go ahead with their studies or their relaxation without evincing interest in committee work. At the moment, however, the active discussions that are taking place daily in Edinburgh or London are going to affect the lives of every medical student in a major way and, where possible, student participation is welcome.

It is important that all those negotiating on behalf of the medical student or doctor should remember that the interests of the patient must be paramount. Despite the expression recently of a contrary view, the National Health Service is run for the benefit of the patient, not for the benefit of members of its staff. The University teacher in the Faculty of Medicine, whether pre-clinical or clinical, is equally involved directly or indirectly in discovering what is wrong with patients and assisting in their management.

### **The New Undergraduate Medical Curriculum**

To the undergraduate, who is going to enter his first pre-registration post after 1979, the new curriculum will be the certain change that is of most direct interest to him. Most students will graduate after five years, as was the case before World War II. The ordinary B.Sc. (Med. Sci.) has been swept away, unmourned by most, but the honours degree remains. There is no doubt that the introduction of a new curriculum creates problems for our teachers and administrators, and it is to be hoped that it will not create too many problems for students. Having lived through various curricular changes and having seen hopes failing to be realized each time, one can only pray that this time the most optimistic forecasts will be the correct ones. Time alone will tell, but it is to be hoped that sufficient flexibility has been built in to obviate the necessity for another massive exercise of the same sort in the 1980s. Such academic convulsions are time consuming.

### **New Professors in the Faculty of Medicine**

Never before have so many new Professors taken up post in such a short period of years. Since 1976 there have been filled Chairs of Biochemistry, Surgery, Obstetrics, Community Medicine, Medicine, Oral Medicine and Pathology, Oral Surgery, Preventive Dentistry, Conservative Dentistry and Respiratory Diseases. Personal Chairs have been created in Pharmacology, Psychiatry and Child Life and Health. Chairs of Bacteriology and Radiology await holders, and outside funds have been provided for Chairs of Rheumatic Disorders, Medical Oncology and Cardiology. On the administrative side we are fortunate in having professor Simpson occupying the post of Executive Dean in succession to Professor Duncan. Other retirements or translations elsewhere are in sight, and all this influx of new ideas (and, no doubt, requests for additional Departmental funds) coincides with both the introduction of the new curriculum and a time of financial restraint.

### **Financial Matters**

The busy medical student may not have time to notice much of what is going on in the outside world, but he cannot have failed to discover that he is pursuing his studies at a time of national and international financial difficulties. Economies are necessary both in the National Health Service and

in the Universities. Those who know about the low financial requirements of the University in the 1930s will have a different idea about what constitutes a financial crisis than will those who entered University life in the time of expansion after the nation had recovered from the war years. In all Faculties economies have had to be made in recent times. Each Department in the Faculty of Medicine has a savings target, and, if that has not been met, there is no University money available to fill the next post that becomes vacant. Meantime, too, the relative amounts of money that may be retained by all Faculties is being studied centrally with a view to re-distribution of the total sum if there is any injustice between Faculties. The intricate interweaving of University and N.H.S. interests and finances in the Faculty of Medicine make meaningful calculations difficult.

### **Salaries**

The average British doctor considers that he is poorly paid, and this is true if the comparison made is with contemporaries in other developed countries or in certain areas of the Middle East. It must be said, however, that the salaries of most full-time members of staff in the pre-clinical departments or in other Faculties are so low as to be derisory. It is not helpful to Universities struggling to retain academic staff to have a Member of Parliament saying in a debate in the House (if correctly reported) that, in supporting the claims of University staff members, those in other political parties are "seeking to cash in on every grievance to make political capital" or that "Extra funds for education should go to the under-fives before University staff". The needs of the under-fives are obvious, and so, too, should be the plight of pre-clinical teachers and those in other Faculties.

At the moment, Lecturers in clinical departments are benefiting from the astonishing agreement that has been negotiated in such a way that some junior doctors receiving large overtime payments have a considerable fall in salary if they become Consultants. It is to be hoped that, in future, Lecturers and junior hospital doctors will receive an adequate basic salary and that, if promoted to Senior Lecturer or Consultant, their salaries will rise, not fall. Surely anyone who may read this number of 'Res Medica' in twenty years' time will find it difficult to believe that the present situation could have existed. If he is not surprised, then he is likely to have emigrated!

The writer of this article held House Posts in the days when these were unpaid. Since there was virtually no off-duty, expenses were low, but a laundry bill had to be paid to the Royal Infirmary. There were no students grants, apart from a possible £50 per annum that could be paid by the Carnegie Trust to Scottish students. It was possible to live as a student or House Officer on five shillings a week, and many did so. Some Ward Sisters still lived in rooms beside their Wards and worked a seven day week. In the writer's student days there was still in post a Ward Sister who had not had a holiday for twenty years. Fortunately, these days are over. There are, however, changes in the opposite direction. In an address to those graduating in 1855, Professor Sir James Young Simpson referred to an Edinburgh graduate of nine year's standing with an income of £5000 per annum. Income tax was the equivalent of 3½p in the £ and in the light of the cost of living of the mid-nineteenth century this was wealth indeed. It is unlikely that any Edinburgh doctor of today earns enough to meet the defence insurance premium of some American specialist surgeons.

It must be remembered, however, that many patients in Britain could not afford medical treatment prior to the introduction of the National Health Service.

### **Devolution**

The differences between many aspects of administration in Scotland from those in England and Wales are, on the whole, beneficial to us. Scotland is sufficiently compact for the "faceless bureaucrats" to be real live people, often well known to the members of the University staff or to colleagues in the N.H.S. It is possible that a telephone message to St. Andrew's House along the lines of "For Heaven's sake, Willie, what are you up to this time?" could be sent from any part of the country. In England such a method of communication is unlikely, particularly from areas outside the metropolis.

The Scottish Medical Deans meet regularly, and jointly meet the Chief Medical Officer at St. Andrew's House to exchange views. Naturally, the Dean and Executive Dean meet daily. The Dean, the Post-Graduate Dean, the President of the Royal College of Physicians of Edinburgh and the President of the Royal College of Surgeons of Edinburgh are in constant touch with each other. The Deans have regular meetings with the Chief Administrative Medical Officer of the Lothian Health Board. On the other hand, there is no real desire amongst the majority for further devolution

in the Universities or in the National Health Service, and the break up of the United Kingdom by separation would be likely to lead to an exodus from Scotland of many members of the academic staff of the Faculty of Medicine if the opinions that have been expressed are to be believed. At the same time, the majority of staff and students want the Medical School to remain an international one rather than become a parochial institution. We are particularly well known abroad for our post-graduate activities.

### **Scottish Health Authorities Revenue Equalisation (the SHARE Report)**

Recently a report has been published on behalf of a Committee established to review the allocation of revenue resources to the various Health Boards in Scotland, something comparable to what has been the subject of a report in England. There are 15 Health Boards in Scotland, with populations ranging from just under 20,000 to just over one million. In England the range is from about 1¼ million to just over 5¼ million. Accordingly, the English model cannot easily be transferred to Scotland. The calculations are complex and include weighting for various factors, including the numbers of undergraduate medical students that are being taught. The report is being studied widely at the moment and the Faculty of Medicine is giving its views, but, if implemented, the percentage share of money for hospital and community services in the Lothian Health Board area will be less, in Tayside much less, and in Ayrshire and Arran and in the Islands much more. Just what that will mean to our present medical students after graduation will depend upon the total sum available for Health Care. This report does not deal with building projects, and it must be stressed that just like the Universities, the N.H.S. is having financial problems.

### **Consultative Document on the Redeployment of 'Acute' Hospital Facilities**

Another matter that is exercising the minds of those in the Faculty of Medicine is that the Lothian Health Board has issued consultative documents revealing their plans for redeployment of acute hospital services. This is mainly something for the future and it is hoped that it will not delay further the rebuilding of the Royal Infirmary and the Western General Hospital.

The suggested long-term plan is to have "acute" beds at five general hospitals, a suggested distribution being 687 at Edinburgh Royal Infirmary, 421 at the Western General Hospital, 420 at the

West Lothian General Hospital (Livingstone), 203 at a 'Southern General Hospital (possibly at Dalkeith) and 100 at Roodlands Hospital (Haddington). There will be 215 acute beds elsewhere. This is based on the expected distribution in population in 1996. Those of us who believed at one time that the rebuilding of the Royal Infirmary and Western General Hospital would have been completed by 1970 are naturally somewhat cynical about any programmes for the future, but, if these new plans are accepted, the pattern of teaching of clinical medical students will have to be altered to adapt to the new situation, and U.G.C. money will be required to match the N.H.S. building programme. No doubt, by the time this happens (if it does), the flow of North Sea oil will have ceased. From whence will come the money?

#### **Peculiarities of the Edinburgh Medical School**

It is obvious that this is a time of intense activity, and, because of its traditions and geographical position, Edinburgh is possibly more heavily involved than other cities. In many ways this is fortunate because it adds spice to life. The Faculty of Medicine celebrated its 250th anniversary in 1976, the Royal Infirmary celebrates its 250th anniversary in 1979, the Royal College of Physicians has its 300th anniversary in 1981 and the University of Edinburgh celebrates its 400th anniversary in 1983. Fortunately, the oldest constituent of the Medical School, the Royal College of Surgeons, is not about to celebrate anything in a major way. The others are setting up committees to organize their celebrations, and the Faculty has just recovered from its efforts.

Edinburgh is not a particularly large capital city, but it has unrivalled medical traditions and is known the world over. It is a favourite place for

medical graduates to wish to carry out their duties, but, because its population is not tremendous, the number of doctors that can be gainfully employed is limited. To this group there turns for co-operation and advice, international bodies, Government Committees, United Kingdom national bodies, overseas Medical Schools, the British Council, the Scottish Home and Health Department, the University of Edinburgh, the Faculty of Medicine, the Lothian Health Board, the Royal Colleges of Surgeons, the Royal Colleges of Physicians, the Royal College of General Practitioners, other Royal Colleges, specialist societies, the Area Medical Committee, the North and South Lothian District, the University Liaison Committee, Specialist Advisory Groups (covering Areas cooperating in our teaching programme) and a vast network of sub-committees spawned by each of these. It is unlikely that anywhere else there can be so many bodies dependent on one Medical School.

No mention is being made of the Dental School in this article, not because it is unimportant, but because it merits a separate account. Here, too, there is an interlocking of interests with other activities of the Faculty of Medicine.

It may be added that Edinburgh is believed to attract more postgraduate doctors than any other Medical School of comparable size, there being more than 1500 in any given year, although some are here to attend short Courses.

We have much to be proud of, not least the quality of our undergraduate medical students. Our entrance requirements are high, but our students are most excellent. As a result, our hospitals are staffed by first class House Officers and so the cycle of excellence is maintained. Despite all that is going on, or perhaps because of it, we can look forward to the future with confidence.

**Floreat res medica Edinburgensis**

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#### **From a dissertation read before the society**

**"Opium eating: its effects and mode of cure"**

**Robert Byers 1853**

"In opium smoking, the first effect of the drug on the Chinese is to render them more loquacious and animated. Gradually their conversation drops, laughter is occasionally produced by the most trifling causes and to these effects succeed vacancy of countenance, pallor and shrinkage of the features."